

FILED MAY 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 15463
Registrar's No. 3669

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). -a.- STATE Mo COUNTY St Louis			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri		c. LENGTH OF STAY (In this place) 1 da		c. CITY OR TOWN St Johns		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 23 St Johns Hosp				e. STREET ADDRESS (If rural, give location) 27 2921 Ridgeway			
3. NAME OF DECEASED (Type or Print) a. (First) FRONA		b. (Middle) _____		c. (Last) WIDEMAN		4. DATE OF DEATH (Month) (Day) (Year) 4-16-57	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 10-24-85	
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) D Richwoods Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Thomas Alexander		13b. MOTHER'S MAIDEN NAME Jones		14. NAME OF HUSBAND OR WIFE G.W. Wideman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS G W Wideman St Johns Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis ANTECEDENT CAUSES Arterio-sclerosis Diabetes mellitus Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Previous coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH one day five years five years	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 260x				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 4-26-56 , 19____, to date _____, 19____, that I last saw the deceased alive on 4-8-57 , 19____, and that death occurred at 3 A m., from the causes and on the date stated above.							
23a. SIGNATURE Scott Neuer MD (Degree or title)				23b. ADDRESS 3903 Park Ave.		23c. DATE SIGNED 4-16-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/18/57		24c. NAME OF CEMETERY OR CREMATORY Oak Grove		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D BY LOCAL REG. APR 17 '57		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ortmann F Home 9222 Lackland Overland Mo			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS
CIVIL SERVICE COMMISSION
ST. LOUIS, MISSOURI

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Al. C. Oitmann*.....

Licensed Embalmer No. *3478*.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.